Enrollment/Change Form

Please print and complete all sections.
See instructions below.

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri

EMPLOYER INFORMATION: To be Completed by Employer

Group Number	Employer Name	Effective Date
9812371	State of Delaware - Cobra	7/01/2012

SUBSCRIBER INFORMATION A: Add (enroll) T: Terminate C: Change (change of name, address or phone)

☐ADD ☐TERM ☐CHG	Gender ☐ M ☐ F	Employee ID	Last Name (Subscriber)	First Name	M.I.	Date of Birth

Social Security Number	Home Street Address	City/State/Zip	Home Phone ( )

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)

☐A ☐T ☐C	Gender ☐ M ☐ F	Last Name (spouse)	First Name	M.I.	Date of Birth
☐A ☐T ☐C	Gender ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth
☐A ☐T ☐C	Gender ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth
☐A ☐T ☐C	Gender ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth
☐A ☐T ☐C	Gender ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth

Signature: _____ Date: _____

Instructions:

Effective date: Beginning date of coverage.
Family Information: List only eligible family members who are enrolling.
Dependent eligibility is the same as employer's health plan.
(A) Add: Open (group) enrollment or new (individual) enrollment during the contract period.
(T) Terminate: To terminate enrollment.
(C) Change: A change of name, address or phone

Please note: ***The enrollment form should be returned to the Statewide Benefit Office and will not be used for any external purpose.***